

**STATE OF MICHIGAN**  
**DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS**  
**OFFICE OF FINANCIAL AND INSURANCE REGULATION**  
**Before the Commissioner of Financial and Insurance Regulation**

**In the matter of**

**XXXXXX**

**Petitioner**

**v**

**File No. 122214-001**

**Blue Cross Blue Shield of Michigan**

**Respondent**

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**Issued and entered**  
**this \_\_\_\_\_ day of December 2011**  
**by R. Kevin Clinton**  
**Commissioner**

**ORDER**

**I. PROCEDURAL BACKGROUND**

On July 6, 2011, XXXXX, authorized representative of her son XXXXX (Petitioner), filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act (PRIRA), MCL 550.1901 *et seq.* After a preliminary review of the request, the Commissioner accepted it on July 13, 2011. The Petitioner has coverage under a group plan underwritten by Blue Cross Blue Shield of Michigan (BCBSM).

The issue in this external review can be decided by a contractual analysis. The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). The contract is BCBSM's *Community Blue Group Benefit Certificate* (the certificate). This matter does not require a medical opinion from an independent review organization.

**II. FACTUAL BACKGROUND**

XXXXXX is a student at a college in XXXXX. He injured his thumb and required surgery which was performed on May 11, 2010, in XXXXX at XXXXXX where the Petitioner also received post-surgery therapy. XXXXXX participates with the Blue Cross Blue Shield system.

BCBSM denied coverage for the Petitioner's therapy. The Petitioner appealed the denial of coverage through BCBSM's internal grievance process. Following a managerial-level conference, BCBSM did not change its decision and issued a final adverse determination dated May 6, 2011.

### III. ISSUE

Did BCBSM properly deny coverage for the therapy Petitioner received at XXXXX from June 23 to August 30, 2010?

### IV. ANALYSIS

#### BCBSM's Argument

In its final adverse determination, BCBSM wrote:

You are covered under the *Community Blue Group Benefits Certificate*. As explained in Section 3: Coverage for Hospital, Facility and Alternatives to Hospital Care, we pay for physical therapy, speech and language pathology services, and occupational therapy when provided for rehabilitation in a hospital (inpatient and outpatient) or in a freestanding physical therapy facility. In Section 4: Coverage for Physician and Other Professional Provider Services it is explained that we pay physician services for physical therapy, speech and language pathology services, and occupational therapy when provided for rehabilitation.

In addition, in the same sections, it states the following:

We pay for physical therapy performed by:

- A doctor of medicine, osteopathy or podiatry

\* \* \*

- A physical therapist in a physician's or independent physical therapist's office
- A independent physical therapist in his or her office

\* \* \*

We do not pay for physical therapy performed by an occupational therapist.

In your son's case, the records substantiate that all of the services provided to Colin were provided by various occupational therapists (i.e., XXXXX, OTR; XXXXX, OTR; XXXXX, OTR; XXXXX, OTR). Because physical therapy performed by an occupational therapist is not a benefit, our denial of XXXX's physical therapy services was appropriate.

As previously explained, occupational therapy is covered when billed by a hospital, freestanding physical therapy facility, or a physician. XXXXX's services were billed by XXXXX, an independent occupational therapy clinic. Because it is not an eligible provider, no payment can be made for his occupational therapy.

### Petitioner's Argument

In her request for external review, the Petitioner's mother wrote:

XXXXX was injured in May, 2010 and had surgery on his thumb to correct the injury. Dr. XXXXX performed the surgery, after which he gave him a prescription for therapy/exercises to strengthen his hand. XXXXX was told to go to XXXXXX for the therapy. BCBSM states that they "do not pay for physical therapy performed by an occupational therapist." We have been assured by the billing department at XXXXX that this was billed as occupational therapy. However, it shows as physical therapy on the EOB forms attached. We are requesting that the entire amount of \$3,587.05 that has been denied by Blue Cross Blue Shield of Michigan be paid to XXXXX.

### Commissioner's Review

In its final adverse determination, BCBSM cited two reasons why the Petitioner's claims should be denied: 1) BCBSM does not provide coverage for physical therapy performed by an occupational therapist, and 2) the therapy billing was not submitted by a hospital, freestanding physical therapy center, or a physician.

With respect to the type of therapy performed, there is disagreement between the Petitioner and BCBSM. The Petitioner has asserted that the therapy in question was occupational therapy, provided by occupational therapists. BCBSM has claimed that its records show that the therapy in question was physical therapy.

The Commissioner notes that insurance claims are processed by insurers using the Current Procedural Terminology (CPT) manual published by the American Medical Association. When describing physical medicine and rehabilitation treatment modalities, the CPT manual does not distinguish between physical and occupational therapy. The manual simply describes the procedures themselves, not the licensing category of the individual who performs the service. However, BCBSM submitted no medical records such as the provider billings, progress notes, or other records to the Commissioner for this review. The Patient Right to Independent Review Act, section 11(9), requires an insurer to provide to the Commissioner "the documents and any

information considered in making the adverse determination or the final adverse determination.” BCBSM has failed to provide the required documents for this review. Having failed to submit required documents, BCBSM may not receive a favorable ruling in this appeal by having the Commissioner accept, without documentation, its assertion that the therapy was physical therapy.

Regarding the nature of the billing entity, the Commissioner notes that the billing was submitted to BCBSM by XXXXX. BCBSM asserted in its final adverse determination that XXXXX is “an independent occupational therapy clinic.” However, the XXXXX web site indicates:

XXXXX, LLC is a physician practice that is independently owned and operated by the physician owners of XXXXX, LLC and is not an affiliate or owned or operated by XXXXX Medical Center.

As an entity owned by physicians (including Dr. XXXXX who prescribed the Petitioner’s therapy), XXXXX satisfies the requirement that the therapists’ services were billed by a physician who employed the therapists who treated the Petitioner. Such treatment is a covered benefit under section 4 of the certificate, page 4.14.

Further, XXXXX is a “freestanding outpatient physical therapy facility” as that term is defined in the *Community Blue* certificate of coverage:

An independently owned and operated facility, separate from a hospital, which provides outpatient physical therapy services and occupational therapy or speech and language pathology services.

The Commissioner finds that BCBSM’s denial of coverage was not consistent with the terms of the certificate.

## **V. ORDER**

Respondent Blue Cross Blue Shield of Michigan’s May 6, 2011, final adverse determination is reversed. BCBSM is required to provide, within 60 days, coverage for the Petitioner’s therapy, subject to any applicable copayments or deductibles.

BCBSM shall, within seven (7) days of providing coverage, provide the Commissioner proof it has implemented the Commissioner’s Order. To enforce this Order, the Petitioner must report any complaint regarding the implementation of this Order to the Office of Financial and Insurance Regulation, Health Plans Division, toll free 877-999-6442.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

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R. Kevin Clinton  
Commissioner